



COPD Toolset: The COPD Care Plan

- Hello and welcome to the learning series for eDOCSNL Practice 360: COPD **Smart Tools for Care.**
- Practice 360 is an ongoing eDOCSNL initiative designed to increase clinical value and practice efficiencies in the Med Access EMR for users in Newfoundland and Labrador. The COPD tools you will see today are the first of many chronic disease management tools that will be developed by the program in the coming months.
- eDOCSNL has partnered with provincial advisory groups and the Family practice renewal program on this development **that aligns to the published COPD Clinical Practice Guidelines. This is a first of its kind initiative that Newfoundland and Labrador and our care providers are leading**
- In this video we will introduce the components of the toolset and give you some idea as to why you might want to use them for the care and monitoring of the patients with COPD in your practice.
- Please keep in mind that all screenshots seen in this video are taken from a test system, so the content may not exactly reflect what you see in your own EMR but be assured the final product will be supported with all the necessary information to ensure you have absolute clarity and knowledge on how to use the toolset effectively in your practice.

Accessing The eDOCSNL COPD Care Plan

The screenshot displays the eDOCSNL COPD Care Plan interface. At the top, patient information is shown: COPD Test, 74 years, 28-Jan-1947, Male, Phone: (709) 123-1234, Provider: K. Dadd. A red alert banner states: "A1c is overdue! Last A1c done > 3 months ago." Below this, a red banner reads: "This 18+ year old patient has not had a BP reading in the last year" and another red banner states: "This patient has not been screened for diabetes in the last three years". The interface includes tabs for Demog, Visits, Tasks, Bills, Allg, Meds, Profile, Labs, Invest, and Consults. The Visits tab is active, showing a table of visits with columns for Date, Status, and Location. The table lists several visits, including one on 2021-01-12 and another on 2020-03-23. The Assessment section includes fields for Diagnosis and Billing Item. The Plan section shows a dropdown menu for selecting a care plan, with options including "eDOCSNL NL COPD Visit Template", "eDOCSNL NL COPD Care Plan", "eDOCSNL NL Preventative Care Goals", "eDOCSNL Diabetes Care Plan", and "eDOCSNL Gestational Diabetes Care Plan". The "eDOCSNL NL COPD Care Plan" is highlighted. The Workflow Actions section includes fields for Disposition and Insurer.

COPD Test
74 years 28-Jan-1947 Male Phone: (709) 123-1234 Provider: K. Dadd

Care Team: Martina Care Flying Solo Martina Kennedy

Demog Visits Tasks Bills Allg Meds Profile Labs Invest Consults

Visit

In Progress

2021-01-12 2020-08-06 2020-06-30 COPD 2020-03-31 test 2020-03-27 test 2020-03-23

Assessment

Diagnosis

Billing Item

Plan

Print Care Plan Task Inv Con Lab Item Med

*eDOCSNL NL COPD Visit Template Select Care Plan

Workflow Actions

Disposition

Insurer NL -

Observations

A1c is overdue! Last A1c done > 3 months ago.

Visit Start Time [Now]

Subjective

Subjective Note

See Code Conditions

Grade 0 Grade 1 Grade 2 Grade 3

Grade 4

Yes No

Show Hide

Show Hide

To access the COPD care plan hover over the “Care plan” icon in the visit and select the eDOCSNL COPD Care plan from the dropdown that appears

The eDOCSNL COPD Care Plan

Patient Summary

Care Plan eDOCSNL COPD Care Plan

Profile

Medical

Status	Onset	Type	Description	Note	Severity	Risk	Updated
<input checked="" type="checkbox"/>	Current	Respiratory	Chronic airflow obstruction			✓	26Feb20
<input checked="" type="checkbox"/>	Current	Respiratory	Chronic bronchitis (disorder)			✓	07Sep20
<input checked="" type="checkbox"/>	Current	Respiratory	COPD - Chronic obstructive pulmonary disease			✓	26Feb20

Lifestyle

Status	Onset	Type	Description	Note	Severity	Risk	Updated
<input checked="" type="checkbox"/>	Current	Non-smoker	eDOCSNL Non-Smoker tobacco Products			✓	03Aug21
<input checked="" type="checkbox"/>	Current	Vaping with Nicotine	eDOCSNL Other inhaled substances			✓	03Aug21
<input checked="" type="checkbox"/>	Current	Vaping without nicotine	eDOCSNL Other inhaled substances			✓	03Aug21
<input checked="" type="checkbox"/>	Current	Smoker	eDOCSNL Smoker tobacco products			✓	03Aug21
<input checked="" type="checkbox"/>	Current	Ex-Smoker <= 5 years	eDOCSNL Ex-Smoker <=5 Years Tobacco products			✓	03Aug21
<input checked="" type="checkbox"/>	Current	Ex-smoker > 5 years	eDOCSNL Ex-Smoker >5 Years Tobacco products			✓	03Aug21
<input checked="" type="checkbox"/>	Current	Marijuana	eDOCSNL Inhaled Cannabinoids			✓	07Apr20

Tasks

Active

Due	Urgency	Owner	Description	Reason	Recur
03Aug21	Normal		Recall, CDM, COPD Recall	COPD	none

Investigations

Active Requests

Date	Urgency	Ordering Provider	Facility	Type	Description	Reason	Observation Status
17Aug21	Normal			Pulmonary Rehab	Investigation, Pulmonary Rehab, Pulmonary rehabilitation	Pulmonary rehabilitation , 15081005	

A care plan is a way to add multiple documentation items or perform multiple tasks simultaneously. This is an efficiency measure that prevents providers from having to navigate to multiple places in a chart to perform tasks one by one. It also enables you to set up recurrent tasks that support the Clinical Practice guidelines principles. When the care plan first appears, all items are checked in blue on the left hand column as seen here.

These checkmarks indicated items that have been selected to apply to the current patient record.

Many of the items may not be applicable to apply to a given patient record so you will want to uncheck the items in bulk so that you can select only the items you want to apply.

This can be done by clicking the right box on the “Chart Summary” line at top left and then unchecking the same box.

The left box here would be clicked to “add details”, this is more applicable to the chart summary function and does not really apply here so do not check this box.

Feature: Profile Items

Patient Summary									
Care Plan eDOCSNL COPD Care Plan									
Profile									
Medical									
<input type="checkbox"/>	Status	Onset	Type	Description	Note	Severity	Risk	Updated	
<input type="checkbox"/>	Current		Respiratory	Chronic airflow obstruction			✓	26Feb20	
<input type="checkbox"/>	Current		Respiratory	Chronic bronchitis (disorder)			✓	07Sep20	
<input type="checkbox"/>	Current		Respiratory	COPD - Chronic obstructive pulmonary disease			✓	26Feb20	
Lifestyle									
<input type="checkbox"/>	Status	Onset	Type	Description	Note	Severity	Risk	Updated	
<input type="checkbox"/>	Current		Non-smoker	eDOCSNL Non-Smoker tobacco Products			✓	03Aug21	
<input type="checkbox"/>	Current		Vaping with Nicotine	eDOCSNL Other inhaled substances			✓	03Aug21	
<input type="checkbox"/>	Current		Vaping without nicotine	eDOCSNL Other inhaled substances			✓	03Aug21	
<input type="checkbox"/>	Current		Smoker	eDOCSNL Smoker tobacco products			✓	03Aug21	

The first section you will see in the care plan is the “Profile” area. Any item you check here will be applied to the patients profile when you apply the care plan.

There are may possible diagnoses here, we have tried to limit them to the items that might be applicable to patients living with COPD.

When items are added to the patient profile they will contribute information to the COPD dashboard and will enable other clinical decision support features.

Note that if you add something here that the patient already has in their profile, due to the functionality of the software a duplicate entry will be created.

Feature: Recurrent Tasks

Tasks

Active

Date	Urgency	Owner	Description	Reason	Recur
03Aug21	Normal		Recall, CDM, COPD Recall	COPD	none

Investigations

Active Requests

Date	Urgency	Ordering Provider	Facility Type	Description	Reason	Observation Status
17Aug21	Normal		Pulmonary Rehab	Investigation, Pulmonary Rehab, Pulmonary rehabilitation	Pulmonary rehabilitation , 15081005	
03Aug21	Normal	Menchions, Stephanie	Pulmonary Function Test	Investigation, Pulmonary Function Test, Pulmonary Function Test LGH	Pulmonary function test , 23426006	
03Aug21	Normal	Menchions, Stephanie	Pulmonary Function Test	Investigation, Pulmonary Function Test, Pulmonary Function Test CH	Pulmonary function test , 23426006	
03Aug21	Normal		Pulmonary Function Test	Investigation, Pulmonary Function Test, Pulmonary Function Test WH	Pulmonary function test , 23426006	
15Jun21	Normal	Kennedy, Martina	Pulmonary Function Test	Investigation, Pulmonary Function Test, Pulmonary Function Test EH	Pulmonary function test , 23426006	

Consults

Active Requests

Date	Urgency	Ordering Provider	Service Provider Type	Description	Reason	Observation Status
17Aug21	Normal		Pulmonary Rehab	Consult, Pulmonary Rehab, COPD Referral for Pulmonary Rehab		

☒ Update or Forward
 ☐ Complete this task

Urgency: Normal
 Recurrence: 6 mo...

TASKS: You can add actions to be completed in the form of tasks to the patient visit from the care plan.

This is an efficiency measure so you don't have to order tasks one by one.

COPD care and monitoring is a continuous exercise so these tasks can be made to be recurrent according to your specifications. When you set up recurrent tasks from the care plan they will automatically appear in your inbox in the designated interval. In the example seen here the provider has selected to recall the patient for care and monitoring at 6 month intervals from within the recall task.

This will serve as a reminder to you that, as in the examples you see here, the patient needs to be seen again or has other elements of care and monitoring that need to be ordered on the interval specified by COPD guidelines

Feature: Goals

Goals							
Active Goals							
<input type="checkbox"/>	Goal Name	Target	Last Value	Last Date	Repeat	Next Due	Met?
<input type="checkbox"/>	Smoking Cessation Advice	Yes			6 month	Unknown	No
<input type="checkbox"/>	Influenza(Flu)			20May2020	1 year	Overdue	No
<input type="checkbox"/>	Pneumococcal vaccination			03Aug2021	5 year	03Aug2026	Yes

GOALS: Patient goals can be set up from the care plan.

These goals are individualized to the particular elements of care and/or monitoring that you want to follow for this patient and have been configured to represent the critical elements of the COPD guidelines.

You do not have to select all the goals for any individual patient, though they are built to align with guidelines.

Select which goals you will apply to the individual patient by clicking the check box to the left of the individual item.

As you can see, satisfying the goals relies on standardized documentation practices and reinforce the use of the visit template. E.g. Smoking Cessation Advice

Applying the Care Plan

The screenshot displays the eDOCSNL interface for applying a care plan. At the top, a yellow box with a green arrow and a red 'X' is positioned above the text 'Apply Care Plan Cancel'. To the right, a 'Goals' sidebar lists 'Active Goals':

Goal	Status	Action
Pneumococcal v...	Unknown	
Smoking Cessatio...	Unknown	
Influenza(Flu)	05Oct2022	

Below the goals, the 'Plan' section features a toolbar with icons for Print, Care Plan, Task, Inv, Con, Lab, Imm, Med, and Draw. The 'Tasks' list includes:

- Recall**, CDM, COPD Recall, assigned to Fred Melindy
- Investigation**, Pulmonary Rehab, Pulmonary rehabilitation assigned to Fred Melindy
- Consult**, Supplemental O2, Referral for Supplemental O2 assigned to Fred Melindy
- Immunization**, Influenza Vaccine, Influenza Vaccine for COPD Patients, completed by Fred Melindy

When you are finished selecting the elements of the care plan you wish to apply to the current patient, click the “Apply Care Plan” icon at the bottom of the care plan, you will then be returned to the patient visit view.

You will see in the “Plan” section, a summary of all the tasks that were ordered as a result of applying the care plan. You can action them individually from here.

Please note that these items are not completed or applied until they are actioned from this area.

Goals that were set up can be viewed from the sidebar view to the right of the patient visit template.

Working with Goals

Goals

Goal Name	Last Date	Last Value	Next Due
Smoking Cessation Advice	03Oct2021		Unknown
Influenza(Flu)	03Oct2021		03Oct2022
Pneumococcal vaccination	03Oct2021		03Oct2026

Active Goals

Goal Name	Last Date	Last Value	Next Due
Smoking Cessation Advice	03Oct2021		Unknown
Influenza(Flu)	03Oct2021		03Oct2022
Pneumococcal vaccination	03Oct2021		03Oct2026

Goal Management

Pneumococcal vaccination: an Immunization task with a type matching or description containing match on within the last

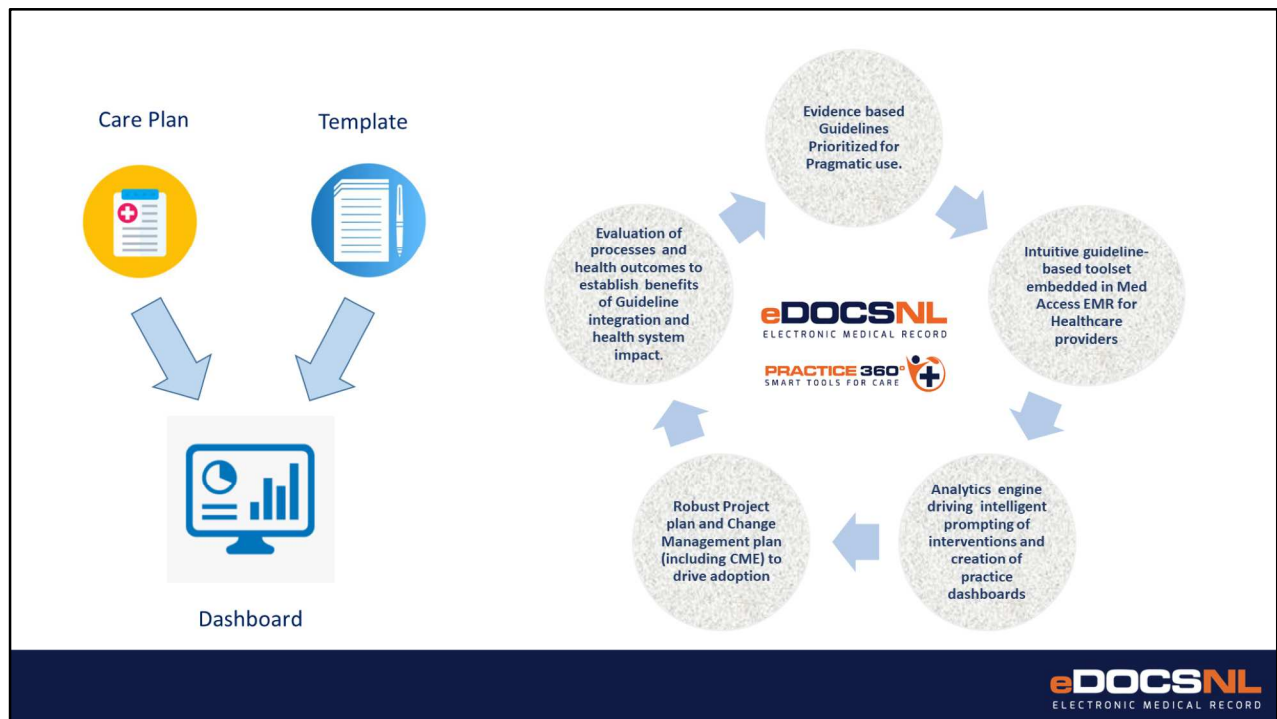
The goals are set up by default to reflect current recommendations in from the COPD guidelines but can be modified if indicated for a given patient.

Right clicking on the goal will produce a menu of options. From here, you can defer a goal to essentially skip a cycle, cancel a goal that you no longer wish to follow, manually enter a result for the value in question (if applicable), and complete the associated task to address the goal. In this example, we will select the Pneumococcal Vaccine goal and notice that you can complete the correct vaccination task directly from the goal itself.

Not all goals lend themselves well to this functionality so this is only applicable to some.

From the goals widget you can also select to change the target and/or frequency of a particular goal for an individual patient if indicated.

For example, if you decide that Pneumococcal vaccines should be given for this particular patient at a different interval than the goal currently specifies you simply select "Change Target/Frequency" from this menu and change the interval on the resulting goal set up window and save. The new goal will now indicate overdue only for the parameters that you set, with the caution that this patient is now being cared for individually rather than strictly according to guidelines.



The components of the toolset are mutually reinforcing.

The documentation template provides all the information to make point of care decisions while automating normally manual tasks, standardizes data input so that the software can enable other features providing clinical value and supports the creation of a data set for providers that can inform population level management. The care plan populates chart information, patient goals and tasks in an efficient way that makes ongoing guidelines-based care and monitoring seamless. The data generated by standardized documentation supported by the patient level tools and visit template informs the COPD dashboard and gives providers a population-level view of COPD in their practice.

This aligns with the eDOCSNL Practice 360 approach of using the intelligent and standardized features of the EMR to support and evaluate guidelines based care, presenting providers with the information they need for best practice decision making. Data provided by the EMR through the Practice 360 tools will enable the evaluation and refinement of guidelines and supports health system changes that will benefit patients living with COPD in Newfoundland and Labrador.

Thank You



Contact us: info@edocsnl.ca

- Thank you reviewing this presentation on the Practice 360: COPD Toolset.
- Please reach out to the program at info@edocsnl.ca if you would like additional information or a focused session with program staff.